



**MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA**

Form No. 1
Date of issue: 10/10/2019
Place of issue: New Delhi

Signature: [Signature]
Name: [Name]
Designation: [Designation]

1. Name of the person: [Name]
2. Address: [Address]
3. Date of birth: [Date]
4. Sex: [Sex]
5. Marital status: [Status]
6. Education: [Education]
7. Occupation: [Occupation]

8. Reason for issue: [Reason]
9. Remarks: [Remarks]

10. Signature of the person: [Signature]
11. Date: [Date]

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19. Reason for issue: [Reason]
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21. Signature of the person: [Signature]
22. Date: [Date]

23. Name of the person: [Name]
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30. Reason for issue: [Reason]
31. Remarks: [Remarks]

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75. Remarks: [Remarks]

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78. Name of the person: [Name]
79. Address: [Address]
80. Date of birth: [Date]
81. Sex: [Sex]
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85. Reason for issue: [Reason]
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